

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/02/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, MCMINNVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS) for Urinary Continence for one resident (#5) of twenty-four residents reviewed.</p>	F 278	<p><b>F278</b></p> <p><b>Actions taken for the Patient(s) affected by the Event.</b> The MDS Coordinator corrected the MDS and resubmitted on 7/31/12 to accurately reflect the urinary continence status of patient #5. A copy of the correction was given to the surveyor.</p> <p><b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> The MDS Coordinator reviewed patients who had colostomies and urostomies to ensure coding was correct on 7/31/12. All coding correct. <b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> All MDS nurses were in-serviced on correct coding procedures on 7/31/12. <b>The corrective actions will be monitored to ensure the practice will not recur.</b> The MDS Coordinator will review section H (bowel and bladder) weekly for 4 weeks on all processed MDS's to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;"><b>Completion Date:</b> 8/03/12</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1  The findings included:  Resident #5 was admitted to the facility on June 14, 2011, with diagnoses including Dysphagia (difficulty swallowing), Muscle Atrophy, Urostomy (artificial opening of the urinary system), Chronic Bladder Outlet Obstruction, and Chronic Renal Failure.  Medical record review of the quarterly MDS dated March 16, 2012, revealed the resident was always continent of urine.  Interview with the MDS Coordinator on July 31, 2012, at 1:39 p.m., in the 400 wing activity room, confirmed the MDS assessment failed to indicate the resident had a urostomy and the MDS assessment was inaccurate.	F 278	F281 Actions taken for the Patient(s) affected by the Event. Review of supplies charged to patient revealed INT/heplock was changed on 7/27/12 and 7/29/12. INT/heplock was discontinued on 7/31/12 and restarted with 24 gauge heplock and dated and initialed. Old and new insertion sites were inspected. No signs nor symptoms of infection nor complications were noted. How we identified other patients having the potential to be affected by the same practice and what corrective action was taken. All patients with IV/INT/heplocks inserted were assessed on 7/31/12. No undated IV/INT/heplock sites were noted. Every IV/INT/heplock site was changed within the 72 hour period. The Measures put in place and systematic changes made to ensure the practice does not recur. All licensed nurses were in-serviced on 7/31/12 and on 8/10/12 on dating, initialing, changing within 72 hours and proper documentation in the nurse's note and on treatment sheets for all IV/INT/heplock dressings. The corrective actions will be monitored to ensure the practice will not recur. The Director of Nursing and Assistant Director of Nursing will monitor every patient with an IV/INT/heplock three times a week for four weeks until substantial compliance is achieved, and then as needed, ensuring dressings are dated, sites are changed every 72 hours, and that the nurse's notes and/or treatment sheets contain the proper documentation. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interviews, the facility failed to follow accepted standards of practice for ensuring an indwelling peripheral catheter is changed in a timely manner, failed to follow a physician's order for the administration of oxygen therapy for one (#7), and timely administration of medication for one (A) of twenty-four residents reviewed.	F 281			8/10/12

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F 281	<p>Continued From page 2</p> <p>The findings included:</p> <p>Resident #7 was admitted to the facility on September 27, 2011, with diagnoses including Osteoarthritis, Fall with Fracture, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Malignant Neoplasm of Bladder, Anxiety, Asthma, and Urostomy.</p> <p>Medical record review of nurse's notes from July 15, 2012, through August 1, 2012, revealed no documentation of the date of the initial placement or date of a peripheral INT (an indwelling intravenous (I.V.) catheter placed in a vein to administer medications or fluids) being changed.</p> <p>Observation on July 31, 2012, at 7:40 a.m., in the resident's room, revealed an INT taped to the resident's right forearm with no date on the tape indicating the date of placement in the resident's arm or when changed last.</p> <p>Review of facility policy, I.V. Dressing and Cannula Site Care, revealed "...8. Standard peripheral I.V. access sites should be changed every 72 hours unless specified by a physician's order..."</p> <p>Interview on July 31, 2012, at 8:30 a.m., with Licensed Practical Nurse (LPN) #3 in the 300 Hallway, confirmed the dressing of the INT had no date indicating the day the INT was placed. Continued interview with LPN #3 confirmed the facility policy is to date the dressing of the INT to ensure the INT is changed every 72 hours per facility policy.</p> <p>Interview on August 2, 2012, at 8:50 a.m., with</p>	F 281	<p>F281 (cont).</p> <p>Actions taken for the Patient(s) affected by the Event. The Oxygen flow rate for patient #7 was corrected to 2 LPM immediately. MD was notified and patient was assessed with no problems noted.</p> <p>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</p> <p>Director of Nursing and Assistant Director of Nursing checked patients on Oxygen for ordered flow rates. No problems noted.</p> <p>The Measures put in place and systematic changes made to ensure the practice does not recur. All licensed nursing staff were in-serviced on 7/31/12, 8/10/12, and on 8/14/12 regarding following physicians orders regarding Oxygen administration and to periodically check Oxygen flow rates while providing care.</p> <p>The corrective actions will be monitored to ensure the practice will not recur. The Director of Nursing and Assistant Director of Nursing will check Oxygen flow rates on all patients weekly times 4 weeks or until substantial compliance is achieved. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p>Completion Date: 8/14/12</p>		

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F 281	<p>Continued From page 3</p> <p>the Director of Nursing (DON), at 300 Unit Nurse's Station, confirmed the facility failed to date the dressing of the resident's INT, and failed to follow the facility's policy by ensuring the dressing of the INT is dated upon insertion.</p> <p>Medical record review of the physician's recapitulation orders signed and dated July 25, 2012, revealed "O2 (oxygen) @ (at) 2 LPM (liters per minute) BNC (by nasal cannula) PRN (as needed) SOB (shortness of breath)."</p> <p>Medical record review of a nursing note dated July 30, 2012, at 10:15 a.m., revealed: "Con't (continue) on O2 at 2-3 LPM BNC."</p> <p>Observation on July 30, 2012, at 2:45 p.m., in the resident's room, revealed the resident lying in the bed, receiving oxygen by nasal cannula at 2.5 liters per minute.</p> <p>Observation on July 31, 2012, at 7:40 a.m., in the resident's room, revealed the resident lying in the bed, receiving oxygen by nasal cannula at 2.5 liters per minute.</p> <p>Interview on July 31, 2012, at 8:30 a.m., with LPN #3, in the resident's room, confirmed the resident was receiving oxygen via nasal cannula at 2.5 liters per minute and the physician's orders had not been followed.</p> <p>Observation of the medication pass, on July 30, 2012, at 8:50 a.m., on the 200 hallway revealed, Licensed Practical Nurse (LPN) #4 prepared a dose of Zolof 100 mg (milligram) oral tablet and administered the tablet to resident #A.</p>	F 281	<p>F281 (cont.)</p> <p><b>Actions taken for the Patient(s) affected by the Event.</b></p> <p>Zolof was rescheduled to be given at bed-time as ordered on 7/30/12. Medical Director was notified and stated AM or PM administration was acceptable. Pharmacy was notified of reschedule and packaging corrected. Patient was assessed by the Charge Nurse and found to have no adverse reactions.</p> <p><b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b></p> <p>Director of Nursing and Assistant Director of Nursing reviewed Medication Administration Records of all patients to ensure medications were being given at prescribed times.</p> <p><b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> All licensed nurses were in-serviced on 7/31/12, 08/10/12, and on 8/14/12 regarding administration of medications at ordered times.</p> <p><b>The corrective actions will be monitored to ensure the practice will not recur.</b> The Director of Nursing and Assistant Director of Nursing to check a sample of Medication Administration Records monthly for four months or until substantial compliance is achieved. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;"><b>Completion Date:</b></p>	8/14/12	

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F 281	Continued From page 4	F 281			
	Medical record review of the Physician's Recapitulation Orders dated July 2012, revealed, "...Zolof 100 mg (milligram) PO (orally) every HS (bedtime) Depression..."				
	Interview with LPN #4 on July 30, 2012 at 10:15 a.m., in the 200 hall nursing station, confirmed the medication was to be given at bedtime daily and the medication was administered during the morning medication pass.				
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			
	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.				
	This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to provide appropriate incontinence care for one (#12) of twenty-four residents reviewed.				
	The findings included:				
	Resident #12 was admitted to the facility on March 14, 2011, with diagnoses including Dementia, Hypertension, Chronic Kidney				

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F 315	<p>Continued From page 5</p> <p>Disease, Anemia, Failure to Thrive, and End Stage Cardiac Disease.</p> <p>Medical record review of the quarterly Minimum Data Set dated May 15, 2011, revealed the resident required extensive assistance with decision making, total assistance with personal hygiene, extensive assistance with all activities of daily living, and was incontinent of bladder and bowel.</p> <p>Observation on August 1, 2012, at 7:58 a.m., in the resident's room, revealed Certified Nursing Assistant (CNA) #3 providing hygiene care following an episode of bowel and bladder incontinence. While performing perineal care, the CNA removed the soiled linens, cleaned the resident's perineal area front to back, turned the resident to the left side, and cleaned the rectal area front to back. Continued observation, at that time, revealed visible stool on the wash cloth. CNA #3 obtained a clean wash cloth, rinsed and dried the rectal area front to back, leaving a small amount of feces on rectal area. CNA #3 positioned the resident on back and applied a clean gown.</p> <p>Review of the facility's Perineal Policy revealed, "Spray soiled and /or odorous areas (or wet washcloth) with product. Gently wipe clean with washcloth, using one area of washcloth for each cleansing stroke. Repeat as necessary, using as many washcloths as needed..."</p> <p>Interview with CNA #3 on August 1, 2012, at 8:15 a.m., in the hall, confirmed feces was left on the resident's rectal area and perineal care was not performed appropriately.</p>	F 315	<p><b>F315</b></p> <p><b>Actions taken for the Patient(s) affected by the Event.</b> C.N.A. #3 immediately returned and provided Incontinence care, removing all traces of feces, and performed urinary catheter care for patient #12 on 8/1/12.</p> <p><b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> All charge nurses monitored catheter and incontinence care for all patients to ensure proper procedures were followed on 8/1/12. The Measures put in place and systematic changes made to ensure the practice does not recur. All licensed nurses and C.N.A.'s were in-serviced on 8/1/12, 8/10/12, 8/14/12, &amp; on 8/16/12 regarding proper catheter care and incontinence care. C.N.A.'s were in-serviced, one-on-one by Education Nurse to ensure understanding and correct procedures were followed regarding incontinence and catheter care.</p> <p>The corrective actions will be monitored to ensure the practice will not recur. The Director of Nursing and Assistant Director of Nursing will check C.N.A. incontinence care for 4 weeks and then monthly for four months until substantial compliance is achieved. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;">Completion Date: 8/16/12</p>		

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F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to apply palm guards for one resident (#8) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on August 5, 2012, with diagnoses including Cerebrovascular Accident (stroke), Bilateral Hemiparesis (weakness), Bilateral Hand Contractures, and Dysphagia (difficulty swallowing).</p> <p>Review of a physician's recapitulation orders dated July 2012, revealed "...palm guards on in the morning...off at bedtime..."</p> <p>Observation on July 31, 2012, at 10:00 a.m., revealed the resident lying in bed with palm guards off.</p> <p>Observation on July 31, 2012, at 12:50 p.m., revealed the resident lying in bed with palm guards off.</p>	F 318	<p>F318</p> <p>Actions taken for the Patient(s) affected by the Event. Patient #8's palm guard was immediately applied after the licensed nurse assessed the patient on 7/31/12. The Occupational Therapist evaluated patient #8's Range of Motion of bilateral hands and fingers and determined no decline.</p> <p>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken. The Occupational Therapist and the charge nurse from each Nursing Station evaluated all patients with palm guard orders and determined all palm guards were being worn as ordered. On 7/31/12.</p> <p>The Measures put in place and systematic changes made to ensure the practice does not recur. All licensed nurses and C.N.A.'s were in-serviced on 7/31/12 and on 8/10/12, 8/14/12 &amp; 8/16/12 regarding the proper placement of palm guards on patients and similar devices. Instructions for placement of palm guards placed on C.N.A. assignment sheets and to be checked daily by each charge nurse. The corrective actions will be monitored to ensure the practice will not recur. Director of Rehab and Occupational Therapist will check proper placement of palm guards on residents weekly times four weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p>Completion Date: 8/16/12</p>		

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F 318	Continued From page 7			F 318			
F 323 SS=D	<p>Interview with Registered Nurse #1 on July 31, 2012, at 12:50 p.m., confirmed palm guards were off and "palm guards are to be on after (resident's) bath..has had bath...they should be on at this time."</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, facility documentation, and interview, the facility failed to ensure appropriate assistance with transfer into a wheelchair van was provided, resulting in a fall without injury for one resident (#10) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on April 20, 2007, with diagnosis of Renal Failure, Diabetes, Left Below Knee Amputation, Depression, Anemia, and Peripheral Neuropathy.</p> <p>Review of the quarterly Minimum Data Set (MDS)</p>			F 323			



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F 323	Continued From page 8 dated February 25, 2012, revealed the resident was cognitively intact (scored a 14 out of 15 indicating a high level of cognitive functioning) Further review of the MDS revealed the resident required the assistance of two people for transfers.  Review of facility documentation dated March 6, 2012, revealed resident #10 fell while being loaded onto the van for transportation to Dialysis. Further review revealed the resident was being loaded into the van by the driver, with no assistance from the facility, the resident's wheelchair flipped backwards, resulting in a fall with no apparent injury.  Interview with the resident on August 1, 2012, at 1:40 p.m., in the Activities Office, revealed the resident had fallen backwards when being loaded onto the van, because the driver had to take off the anti-tipping wheels from the back of the resident's wheelchair in order to transverse the lip of the ramp onto the van, and lost control of the resident's wheelchair.  Interview with the Director of Nursing (DON) on August 1, 2012, at 11:25 a.m., in the conference room, confirmed that the facility had failed to provide the assistance required when loading the resident onto the van.	F 323	<b>F323</b> <b>Actions taken for the Patient(s) affected by the Event.</b> Patient was evaluated by physical therapist and a new wheelchair was given to patient #10 on 03/13/12 that was less a risk for tipping and easier to load on transportation van. Director of Nursing coordinated with transportation and patient's charge nurse to have center staff available to assist with loading of patient onto transportation van. <b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> The Maintenance Director and Maintenance Assistant checked all wheelchairs and mobility assistive devices in the center for proper functioning and preventive maintenance needs on 3/29/12. All patient's wheelchairs were assessed by the Director of Nursing and Assistant Director of Nursing who utilize similar transportation for outings and center staff were made available for assistance in loading onto transportation on 8/02/12 and ongoing. <b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> All licensed nursing and C.N.A.'s were in-serviced on providing assistance with loading of patients for transportation from the center on 8/02/12, 8/14/12 & 8/16/12. <b>The corrective actions will be monitored to ensure the practice will not recur.</b> Director of Nursing and Assistant Director of Nursing will monitor that patients are being assisted with loading into transportation weekly times four weeks or until substantial compliance is achieved. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		Completion Date: 8/16/12	

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MCMINNVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
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F 371	<p>Continued From page 9 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary storage of food and equipment.</p> <p>The findings included:</p> <p>Observation of the dietary department on July 30, 2012, from 10:00 a.m. until 11:15 a.m., revealed:</p> <ol style="list-style-type: none"> <li>1. Two seven pound cans of Pork and Beans were dented and were available for use;</li> <li>2. Eight wet pans stored under the steamer were wet and were available for use;</li> <li>3. A box of crackers opened and not labeled with date when opened;</li> <li>4. A stand up mixer had food debris on the lip and top of the machine and was available for use;</li> <li>5. A dirty ice cream scoop had dried Pimento Cheese on it and was available for use;</li> <li>6. Four wet ladles were found in the drawer available for use;</li> <li>7. The bottom plate warmer holder had crumbs under the three lids that were falling onto the plate warmers that were available for use;</li> <li>8. The sanitizer section of the three compartment sink tested at 75 p.p.m. (parts per million) instead of the required 200 p.p.m. The staff continued to use this section of the sink for sanitizing the pots and pans.</li> </ol> <p>Interview with the dietary manager on July 30,</p>	F 371	<p><b>P371</b> <b>Corrected Actions Accomplished.</b> The two dented seven pound cans of Pork and Beans were immediately removed. The eight wet pans stored under the steamer were removed and cleaned and dried properly. The box of opened crackers were immediately removed and disposed. The stand up mixer was immediately cleaned and was free of debris. The dirty ice scoop was immediately cleaned and dried properly, removing all food debris. The four wet ladles were immediately removed and cleaned and dried properly. The plate warmer was immediately cleaned and was free of crumbs. The sanitizer section of the three sink compartment was adjusted to the required 200 p.p.m.. Any pots cleaned were re-cleaned at the proper sanitizer levels. All occurred on 7/30/12. The two staff drink bottles were removed from the dietary freezer and a Wet Floor Sign was placed in the dish room on 7/31/12.</p> <p><b>How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.</b> All can goods were checked for dents, all pans, ladles, and scoops available for use in were inspected for proper cleaning and storage, all food processing equipment was checked for proper cleaning along with all plate and warmer storage areas. The three sink compartment sanitizer was recalibrated and checked at 200 p.p.m. on 7/30/12. The Dietary Manager checked all dietary coolers and freezers to ensure no staff drink and or food items were stored. The Dietary manager ensured that any wet areas in the dietary area had proper signage on 7/31/12. <i>(continued on next page)</i></p>		

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F 371	<p>Continued From page 10</p> <p>2012, at 11:15 a.m., in the dietary department, confirmed dented cans were to be removed from stock, the ladles and pans needed to dry completely before being stored for use, all open food was to be labeled with the date and closed completely prior to storage, the stand up mixer was to be cleaned completely after each use before storage, the ice cream scoop used for Pimento Cheese was to be cleaned prior to storage, the bottom plate warmer storage container was to be clean from debris at all times, and the three compartment sink sanitizer section was to be kept at the acceptable sanitizer level at all time.</p> <p>Continued observation of the dietary department on July 31, 2012, from 8:00 a.m. to 9:35 a.m., revealed:</p> <ol style="list-style-type: none"> <li>Two staff bottle drinks were found in the first floor dietary freezer;</li> <li>The floor in the dishwasher section of the main dietary department had free standing water on it without a Wet Floor Sign present.</li> </ol> <p>Interview with the dietary manager on July 31, 2012, at 9:40 a.m., in the dietary department, confirmed the staff drinks were not to be in the dietary freezer, and there needed to be a Wet Floor Sign in the dishwasher area of the kitchen.</p>	F 371	<p>F371(cont.)</p> <p><b>How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.</b> All Dietary Staff were in-serviced on proper cleaning and drying of food containers, dispensers, food processing equipment and dish storage areas, proper labeling of food items, removal of any dented cans and the proper use of "Wet Floor Signage" on 8/30/12. All staff were in-serviced on not placing personal drink and or food items in dietary coolers or dietary freezers.</p> <p><b>The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.</b> Dietary Manager to check dry storage area for dented cans, the proper cleaning and storage of food service utensils/pans, proper labeling of food items, proper cleaning of food equipment and dish storage areas, proper sanitizer levels in the three sink compartment, staff drinks in dietary freezers, and the use of Wet Floor Signs in the Dietary area weekly times four weeks and then monthly times 4 months to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;">Completion Date: 8/30/12</p>		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MCMINNIVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
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F 431	<p>Continued From page 11</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly store medical supplies in one medication storage room of four medication storage rooms reviewed.</p> <p>The findings included:</p> <p>Observation on July 30, 2012, at 8:50 a.m., in the</p>	F 431	<p>F431</p> <p>Actions taken for the Patient(s) affected by the Event. The 30ML bottle of 0.9 percent normal saline, opened bottle of cornstarch and opened sterile urinary catheter tray were immediately discarded by the charge nurse on 7/30/12.</p> <p>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken. All medication storage areas were inspected by the Director of Nursing, Assistant Director of Nursing and charge nurses on 7/30/12 with no additional findings.</p> <p>The Measures put in place and systematic changes made to ensure the practice does not recur. All licensed nurses were in-serviced on 7/30/12, 8/10/12, &amp; 8/14/12 on proper labeling, storage and discarding of all drugs and biologicals.</p> <p>The corrective actions will be monitored to ensure the practice will not recur. Medication storage areas will be checked by the Director of Nursing and Assistant Director of Nursing for the proper storage, labeling and discarding of all drugs and biological weekly times four weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nursing, Health Information and Assistant Director of Nursing).</p> <p>Completion Date: 8/14/12</p>		

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F 431	Continued From page 12 200 hall medication room, revealed one 30ML (milliliter) bottle of 0.9 percent normal saline, opened and unlabeled and ready for resident use. Continued observation revealed one box of cornstarch powder opened and unlabeled, ready for resident use. Continued observation revealed a sterile urinary catheter tray, opened and stored in the sterile supply cabinet, ready for resident use.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441			

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F 441	<p>Continued From page 13</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain infection control measures for four resident's (#10, #14, #B, #12) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on April 20, 2007, with diagnoses of Renal Failure, Diabetes, Left Below Knee Amputation, Depression, Anemia, and Peripheral Neuropathy.</p> <p>Observation of catheter care for resident #10 on July 31, 2012, revealed the Certified Nursing Assistant (CNA) #2 had donned gloves after washing hands. CNA #2 proceeded to draw the curtains, close the blinds, turn the resident,</p>	F 441	<p>F441</p> <p>Actions taken for the Patient(s) affected by the Event. C.N.A. immediately instructed to return to patient #10's room and to clean and disinfect supplies on 7/31/12.</p> <p>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</p> <p>Director of Nursing, Assistant Director of Nursing and charge nurses observed C.N.A. personal care on 7/31/12 and noted no further issues.</p> <p>The Measures put in place and systematic changes made to ensure the practice does not recur. All licensed nurses and C.N.A.'s were in-serviced on 7/31/12 and 8/10/12 regarding proper infection control techniques while providing personal care including changing gloves between tasks and when needed if gloves become soiled.</p> <p>The corrective actions will be monitored to ensure the practice will not recur. Director of Nursing, Assistant Director of Nursing and Education Nurse will visualize C.N.A.'s providing personal care weekly times four weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nursing, Health Information and Assistant Director of Nursing).</p> <p>Completion Date: 8/10/12</p>		

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F 441	<p>Continued From page 14</p> <p>remove the resident's soiled brief, perform catheter care,, and put away supplies with the same pair of dirty gloves.</p> <p>Interview with CNA #2 on July 31, 2012, at 1:53 p.m., confirmed the CNA had proceeded with catheter care and clean-up with the same pair of soiled gloves.</p> <p>Observation of resident #10 during medication pass conducted on July 31, 2012, at 11:00 a.m., on the 300 corridor, revealed Licensed Practical Nurse (LPN) #3 withdrew six units of Novolin R (short acting insulin used for the treatment of elevated blood sugar levels) from the medication vial without cleansing the vial prior to inserting the sterile needle. Continued observation revealed LPN #3 entered the resident's room, and administered the injection.</p> <p>Interview with LPN #3 on July 31, 2012, at 11:25 a.m. in the 300 hallway corridor confirmed the medication was withdrawn from the medication vial without cleansing the vial prior to accessing it with the sterile needle.</p> <p>Resident #14 was admitted to the facility on March 7, 2009, with diagnoses including Basal Cell Carcinoma Left Temple, Severe Vascular Dementia, Hypertension, Diabetes, and Atrial Fibrillation.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated, June 23, 2012, revealed the resident was severely cognitively impaired, and dependent for</p>	F 441	<p>F441 (cont.)</p> <p><b>Actions taken for the Patient(s) affected by the Event.</b> Site of injection on patient #10 was monitored by the charge nurse for signs and symptoms of infection beginning 7/31/12. C.N.A. and licensed Nurse sldn assessments were monitored by the Assistant Director of Nursing beginning 7/31/12 for signs and symptoms of infection. None noted.</p> <p><b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> Director of Nursing and Assistant Director of Nursing interviewed all licensed nurses and reviewed correct procedures for administering injectable medications on 7/31/12.</p> <p><b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> All licensed nurses were in-serviced on 7/31/12, 8/02/12 and 8/14/12 on proper techniques when administering injectable medications.</p> <p><b>The corrective actions will be monitored to ensure the practice will not recur.</b> The Director of Nursing and Assistant Director of Nursing will conduct medication pass audits weekly times four weeks to ensure proper technique for the administration of injectable medications. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nursing, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;"><b>Completion Date:</b> 8/14/12</p>		

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F 441	<p>Continued From page 15 activities of daily living.</p> <p>Observation of Resident #14 on July 30, 2012, at 11:40 a.m., in the resident's room, during initial tour, revealed the resident lying supine on the bed. Observation revealed a dislodged gauze dressing, above the resident's left temple. Continued observation revealed, beneath the dislodged dressing a golf ball sized black tumor extending upward from the resident's temple exposed to open air. Yellow drainage was visible on the dislodged dressing.</p> <p>Medical record review of the Physician's Recapitulation Orders dated July 2012, revealed orders to keep the tumor site covered with gauze dressings, and to change the dressings daily, and as needed when soiled.</p> <p>Interview with LPN #2, on July 30, 2012, at 11:45 a.m., in the resident's room, confirmed the dressing on the resident's head did not cover the tumor.</p> <p>Resident B was admitted to the facility on March 11, 2009, with diagnoses including Hypertension, Diabetes, Late Effects of Cerebral Vascular Accident (stroke), Cardiomegaly, and Congestive Heart Failure.</p> <p>Observation of Resident B during the medication pass on July, 31, 2012, at 11:20 a.m., revealed LPN #3 failed to wash the hands prior to donning gloves and administering three units of subcutaneous Novolin R ( short acting insulin used to treat elevated blood sugar levels) to the</p>	F 441	<p><b>F441 (cont.)</b> <b>Actions taken for the Patient(s) affected by the Event.</b> Patient #14 was immediately assessed for complications with wound site on 7/30/12. None noted. Patient #14's dressing was removed and a clean dry dressing re-applied. Medical Director was notified and changed the dressing order to include a more occlusive dressing secured with mexitape.</p> <p><b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> All patient's dressings were assessed by the charge nurses throughout the building on 7/30/12 with no findings.</p> <p><b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> All licensed nurses were in-serviced on 7/30/12 and 8/10/12 regarding the frequent monitoring of patient dressings and to reinforce or change dressings as needed.</p> <p><b>The corrective actions will be monitored to ensure the practice will not recur.</b> The center Wound Care Nurse to check patient dressings weekly times four weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nurses, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;"><b>Completion Date:</b> 8/10/12</p>		



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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MCMINNVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
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F 441	<p>Continued From page 16 resident.</p> <p>Interview with LPN #3 on July 31, 2012, at 11:25 a.m., in the hallway outside the resident's room, confirmed the hands were not washed prior to donning gloves and administering the injection.</p> <p>Resident #12 was admitted to the facility on March 14, 2011, with diagnoses including Dementia, Hypertension, Chronic Kidney Disease, Anemia, Failure to Thrive, and End Stage Cardiac Disease.</p> <p>Medical record review of the quarterly Minimum Data Set dated May 15, 2011, revealed the resident required extensive assistance with decision making, total assistance with personal hygiene, extensive assistance with all activities of daily living, and was incontinent of bladder and bowel.</p> <p>Observation on August 1, 2012, at 7:58 a.m., in the resident's room, revealed Certified Nursing Assistant (CNA) #3 providing hygiene care following an episode of bowel and bladder incontinence. While performing perineal care, the CNA removed the soiled linens, placed linens in a plastic bag, cleaned the resident's perineal area front to back, positioned resident on left side, and rolled the soiled bed pads under the resident's buttocks. CNA #3 placed two clean pads under the resident's buttocks. Continued observation, at that time, revealed a pillow fell to the floor. CNA #3 picked the pillow up from the floor, placed it on a chair, touched the rail of the bed, touched the resident, and continued with hygiene</p>	F 441	<p><b>F441 (cont.)</b> <b>Actions taken for the Patient(s) affected by the Event.</b> Site of injection on patient B was monitored by the charge nurse for signs and symptoms of infection beginning 7/31/12. C.N.A. and licensed Nurse skin assessments were monitored by the Assistant Director of Nursing beginning 7/31/12 for signs and symptoms of infection. None noted. <b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> Reviewed proper technique of gloving and hand washing during injection administration with all licensed nurses on 7/31/12. <b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> All licensed nurses were in-serviced by Director of Nursing and Assistant Director of Nursing on 7/31/12 and 8/10/12 on proper infection control techniques to include hand washing before donning of gloves. <b>The corrective actions will be monitored to ensure the practice will not recur.</b> Director of Nursing and Assistant Director of Nursing will conduct medication pass audits to include monitoring of proper hand washing and donning of gloves weekly times four weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nursing, Health Information and Assistant Director of Nursing). <b>Completion Date:</b></p>		8/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/02/2012
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, MCMINNVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
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F 441	Continued From page 17 care without changing gloves.  Interview with CNA #3 on August 1, 2012, at 8:15 a.m., in the hall, confirmed the soiled gloves were not removed before applying the clean pads, picking the pillow off floor, touching the bed rail and the resident. Continued interview confirmed appropriate infection control was not maintained.	F 441	F441 (cont) Actions taken for the Patient(s) affected by the Event. Director of Nursing immediately directed C.N.A. to cleanse items touched with soiled gloves and patient linens were immediately removed and replaced with clean linens on 8/1/12. How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to maintain an accurate clinical record for one (#7) resident of twenty-four residents reviewed.  The findings included:  Resident #7 was admitted to the facility on September 27, 2011, with diagnoses including Osteoarthritis, Fall with Fracture, Chronic	F 514	Nursing, Assistant Director of Nursing and charge nurses observed C.N.A. personal care on 8/1/12 and noted no further issues. The Measures put in place and systematic changes made to ensure the practice does not recur. Director of Nursing and Assistant Director of Nursing in-serviced all licensed nurses and C.N.A.'s regarding infection control techniques including changing gloves between tasks and the removal of gloves and washing of hands prior to touching clean items on 8/1/12 and 8/10/12. The corrective actions will be monitored to ensure the practice will not recur. Director of Nursing, Assistant Director of Nursing and Education Nurse will visualize C.N.A.'s providing personal care weekly times four weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nursing, Health Information and Assistant Director of Nursing). Completion Date: 8/10/12		

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F 514	<p>Continued From page 18</p> <p>Obstructive Pulmonary Disease, Congestive Heart Failure, Malignant Neoplasm of Bladder, Anxiety, Asthma, and Urostomy.</p> <p>Medical record review of nurse's notes from July 15, 2012, through August 1, 2012, revealed no documentation of the date of the initial placement or date of a peripheral INT (an indwelling intravenous (I.V.) catheter placed in a vein to administer medications or fluids) being changed.</p> <p>Observation on July 31, 2012, at 7:40 a.m., in the resident's room, revealed an INT taped to the resident's right forearm with no date on the tape indicating the date of placement in the resident's arm or when changed last.</p> <p>Interview on August 2, 2012 at 8:50 a.m., with the Director of Nursing (DON), at 300 Unit Nurse's Station, confirmed the facility failed to accurately document the status of the resident's INT placement, and failed to accurately reflect the status of the resident's INT in the clinical record.</p>	F 514	<p><b>F514</b></p> <p><b>Actions taken for the Patient(s) affected by the Event.</b> Review of supplies charged to patient revealed INT/heplock was changed on 7/27/12 and 7/29/12. INT/heplock was discontinued on 7/31/12 and restarted with 24 gauge heplock and dated, initialed and documented in the medical record.</p> <p><b>How we identified other patients having the potential to be affected by the same practice and what corrective action was taken.</b> The Director of Nursing and Assistant Director of Nursing assessed all patients with an IV/heplock inserted on 7/31/12 to ensure sites were initialed, dated and recorded in the medical record with no findings.</p> <p><b>The Measures put in place and systematic changes made to ensure the practice does not recur.</b> The Director of Nursing and Assistant Director of Nursing in-serviced all licensed nurses on 7/31/12 and 8/10/12 regarding dating, initialing and documenting in the medical record all IV/heplock changes.</p> <p><b>The corrective actions will be monitored to ensure the practice will not recur.</b> The Director of Nursing and Assistant Director of Nursing will monitor all patients with an IVIV/heplock for proper dating, initialing and documentation in the medical record weekly for four weeks to ensure substantial compliance is achieved. Results will be reported to the QA Committee (Administrator, Medical Director, Director of Nursing, Health Information and Assistant Director of Nursing).</p> <p style="text-align: right;"><b>Completion Date:</b> 8/10/12</p>		